for which he or she attends. I doubt if a case for assault or trespass would readily be brought if treatment were enforced; many chronic schizophrenics will be saved from further breakdown by enforced treatment with psychotropic drugs that maintains them reasonably well in the community and at work and is usually accepted without demur.

SEYMOUR SPENCER

Headington,
Oxford OX3 7LW

Points

Treatment of cutaneous leishmaniasis

Dr ANTHONY BRYCESON (Hospital for Tropical Diseases, London NW1 0PE) writes: Mr Michael A Currie (15 October, p 1105) writes of his experience with curettage in the treatment of cutaneous leishmaniasis in Pakistan. Curettage was standard treatment in India until 1947 when Elkerton carried out the first controlled trial of treatment.[1] He showed that intralesional injections of 5% mepacrine, given on one to three occasions at three to five day intervals, healed 67% of sores in four weeks and 100% in nine weeks, which was marginally superior to curettage. This is the only controlled trial ever carried out for cutaneous leishmaniasis. Mepacrine is no longer generally available and the wheel has come full circle. Mr Currie's paper emphasises the absence of any proved method of treatment that is suitable for outpatient use. New methods and proper trials are sorely needed.[2]

[1] Elkerton LE. Oriental sore—atebrin treatment. *Indian Medical Gazette* 1947;**79**:519-21.
[2] Jolliffe DS, Bryceson ADM. Cryotherapy in cutaneous leishmaniasis. *Br J Dermatol* 1983;**109**:489-90.

Parathyroid hormone and 25-hydroxyvitamin D concentrations in elderly people

Dr NIGEL LAWSON and Dr ANDREW J TAYLOR (Department of Clinical Chemistry, East Birmingham Hospital, Birmingham B9 5ST) write: We read with interest the letter from Dr Roger A Fisken (22 October, p 1225) concerning serum parathyroid hormone measurements and primary hyperparathyroidism. We feel that it is necessary to point out that an erroneous diagnosis of primary hyperparathyroidism may be made if only serum parathyroid hormone and calcium concentrations are measured, as tertiary hyperparathyroidism will give similar results. Careful consideration of previous history, serum alkaline phosphatase activities, and the presence of osteomalacia will help to distinguish between these two forms of hypercalcaemia.

Q fever

Dr PAUL M FLEISS (Los Angeles, California 90027) writes: The recommendation by Professor Alasdair M Geddes (1 October, p 927) that patients being prepared for heart valve replacement should be screened for *Coxiella burnetii* phase I antibodies should be generally accepted. *C burnetii* is potentially present wherever livestock are or have been congregated,[1] and human infection is usually related to more or less direct contact with sheep, goats, or cattle. It may be airborne over long distances, contaminated fields and roadways may serve as loci for airborne dissemination of the rickettsia,[2] and contamination of the clothing[3] of those persons handling sheep may be a means of transporting the rickettsia. . . . The organism has been isolated from milk, urine, faeces, and oral and nasal secretions of experimentally infected animals, but no case of clinical Q fever in humans attributed to the ingestion of raw milk products has been reported.[1] Q fever is a difficult disease to diagnose clinically and there is probably a large number of undiagnosed asymptomatic cases. Although theoretically the organism may be transmitted by other vectors, all reported clinical cases in man have occurred by inhalation of infected aerosol particles.

[1] Leedom JM. *Q* fever: an update. In: Remington JS, Swartz MN, eds. *Current clinical topics in infectious disease*. New York: McGraw Hill, 1980:304-31.
[2] Salmon MM, Howells B, Glencross EJG, Evans AD, Palmer SR. Q fever in an urban area. *Lancet* 1982;i:1002-4.
[3] Oliphant JW, Gordon D, Meis A, Parker RR. Q fever in laundry workers: presumably transmitted from contaminated clothing. *American Journal of Hygiene* 1949;**76**:49.

A National Museum of Health

R F FISHER (Park Hill Village, Croydon CR0 5NV) writes: I wish to add my support for the idea of a National Museum of Health (8 October, p 1068). Considering the large number of redundant purpose built hospitals and workhouses in Britain the provision of fabric should not be a problem. Finance could be provided to a large extent from the many commercial organisations which exist as a result of the NHS and private sector. The commercial world assists sport and the arts with subsidies so there is no reason why the same sort of generosity could not be extended to a museum. If the museum becomes an adjunct of the Science Museum, which now maintains the Wellcome collection, the problem of management could also be resolved. Between 1974 and 1983 a whole level of "management" was created and disbanded; where will the records of that exercise be 15 years from now?

Possible hepatotoxicity of zimelidine

Dr C N SAWYER, Dr JOHN CLEARY, and Dr ROGER GABRIEL (St Charles's Hospital, London W10 6DZ) write: Like Dr G K Simpson and Dr N McD Davidson (22 October, p 1181) we have managed a patient who developed systemic symptoms, fever, and abnormalities of liver function while taking zimelidine. Increase in the concentrations of alanine aspartate transaminase and alkaline phosphatase were of the same order as those recorded by Simpson and Davidson, but there was no jaundice . . . . Zimelidine, the only drug our patient took, was stopped, and symptoms abated within three days, and results of liver function tests returned to normal in 11 days.

During the drug fever C reactive protein reached a peak of 47 mg/l and fell to normal within 4 days of discontinuing the drug. At this stage haemolytic activity of complement was 55% greater than normal, the concentration of C3 35% above normal and the concentration of C4 was normal. Circulating immune complexes were present containing Clq, IgG and IgM and persisted for five weeks.

These immunological abnormalities have not been previously recorded and although zimelidine has been withdrawn from the market we understand that two or three similar compounds are at present under development. . . .

Plasma concentrations of zimelidine and norzimelidine were measured by courtesy of the Poisons Unit, New Cross Hospital.

Testing efficacy of proposed new consultant appointments

Professor D N BARON (Department of Chemical Pathology, Royal Free Hospital, London NW3 2QG) writes: Your two leading articles of 29 October ("The end of clinical freedom" (p 1237) and "Nuclear medicine in district general hospitals" (p 1238)) need to be studied together. Before we appoint consultants in nuclear medicine we have to evaluate whether they are cost effective. Can they provide a better service in nuclear medicine, without additional expense, than at present organised by pathologists (radioimmunoassays), radiologists (imaging), radiotherapists (treatment), and physicists (radiation protection)? We are in a zero sum health service, and one more consultant in nuclear medicine means one less consultant in something else.

Dr John Bodkin Adams

Mr PERCY HOSKINS (*Daily Express*, London EC4P 4JT) writes: Dr Michael O'Donnell (29 October, p 1311) mentions that I was a beneficiary under Dr John Bodkin Adams's will in recognition of my "voice in the wilderness" campaign to secure for him a fair trial, despite an incredible witchhunt. I think in fairness it should be added that directly the executors informed me of the legacy I donated it to the liver unit at King's College Hospital.

Personal papers

Dr DORIS JACKSON (Sidcup, Kent) writes: It would appear that the *BMJ* is beginning to join the media's bandwagon in publishing "Personal papers." For several weeks I have seen revelations of the physical, mental, and psychological traumas of various readers who presumably wish to bare themselves to the public eye. I feel that a little reticence would be more becoming in our members. After all, few of us have *not* suffered in some way. Have you nothing else in the way of subject matter with which to fill our journal?

Medical care in South Africa

Dr ADRIAN HASTINGS (Glyncorrwg, Port Talbot, West Glamorgan) writes: Mr M S C Nelemans (1 October, p 985) thinks the people of South Africa are happy and lucky with the medical care available to them. Luck, of course, does not enter into it. The good fortune is distributed—like everything else in South Africa—according to the colour of one's skin. The wealth to provide a health service is created by all races in South Africa, but the allocation of resources is entirely controlled by whites.

I spent three years working in a health centre in Maputo, Mozambique, where many refugees from South Africa lived. They were very impressed by the extensive health care facilities available to everyone in Mozambique, which they said outstripped anything for blacks in South Africa. . . .This comprehensive health service is provided by one of the world's poorest countries. A small fraction of the wealth so conspicuously consumed by white South Africa could provide a similar service in South Africa. White South Africans will claim that my informants were biased in their attitudes. They are probably right. Many of my patients were suffering the long term physical and mental effects of torture while in detention for such "crimes" as organising political opposition to the régime.

Are herbal cigarettes a health hazard?

Dr I REDSTONE (Honeyrose Products Ltd, Stowmarket, Suffolk IP14 5AY) writes: As we are the principal manufacturers of herbal (coltsfoot) cigarettes in the United Kingdom I read with interest the answer of Dr Francis J C Roe (22 October, p 1202) to the question "Are herbal cigarettes a health hazard?" His answer was—as it inevitably must be for any product—that it would be unsafe to assume that herbal cigarettes carry *no* health hazard. The important question for your readers, however, is, are cigarettes made from herbs other than tobacco less hazardous to health than those that are made from tobacco? As far as our coltsfoot—a medicinal herb—cigarettes are concerned, (*a*) they do not contain nicotine, the hazards of which are well documented; (*b*) they are not habit forming . . . (*c*) they help those smokers to give up smoking if they so wish, by helping them to cope with the symptoms of nicotine withdrawal. . . .